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	15G464	A. BUILDING 00 B. WING	10/26/2012

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ARC OF NORTHWEST INDIANA INC, THE	2414 WOODLANE MERRILLVILLE, IN 46410

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W0000		W0000		

This visit was for a full recertification and state licensure survey. This visit included the investigation of complaint #IN00118284.

Complaint #IN00118284: SUBSTANTIATED, Federal and state deficiencies related to the allegations are cited at W102, W104, W122, W149, W153, W318 and W331.

Dates of survey: October 15, 17, 18, 19 and 26, 2012

Facility number: 000978
Provider number: 15G464
AIM number: 100249370

Surveyor: Christine Colon, Medical Surveyor III/QMRP

The following deficiencies also reflect state findings in accordance with 460 IAC 9.
Quality Review completed 11/2/12 by Ruth Shackelford, Medical Surveyor III.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W0102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review and interview for 1 of 3 sampled clients (client A), the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to exercise operating direction over the facility to ensure the facility implemented their policy and procedures to prevent neglect of client A and to ensure the health needs of client A were met. The governing body failed for 5 of 5 clients living at the group home (clients A, B, C, D and E) to exercise operating direction over the facility to complete routine maintenance. Findings include: 1. Please refer to W122. The governing body failed to exercise general policy and operating direction over the facility in regards to meeting the Condition of Participation: Client Protections. The governing body neglected to implement their neglect policy and neglected to protect 1 of 1 client (client A), from an injury of unknown origin to her ear and hospitalization of client A. 2. Please refer to W318. The governing body failed to exercise operating direction	W0102	See reference tag W122	11/27/2012

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	over the facility nursing services to meet the Condition of Participation: Health Care Services. The governing body failed to provide adequate nursing services/prompt treatment for 1 of 3 sampled clients (client A). 3. Please refer to W104. The governing body failed to exercise operating direction over the facility to ensure their neglect policy was followed and neglected to protect 1 of 3 sampled clients (client A) from an unknown injury which resulted in hospitalization. The governing body failed for 5 of 5 clients living at the group home (clients A, B, C, D and E) to exercise operating direction over the facility to complete routine maintenance. This federal tag relates to complaint #IN00118284. 9-3-1(a)			

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W0104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview, the governing body failed to exercise operating direction over the facility to ensure their neglect policy was followed and neglected to protect 1 of 3 sampled clients (client A) from an unknown injury which resulted in hospitalization. The governing body failed for 5 of 5 clients living at the group home (clients A, B, C, D and E) to exercise operating direction over the facility to complete routine maintenance. Findings include: 1. Please refer to W149. The governing body failed to exercise general policy and operating direction over the facility to implement its "Policy for Handling Cases of Neglect and Abuse" for 1 of 3 sampled clients (client A) who was hospitalized for an unknown injury. 2. Please refer to W331. The governing body failed for 1 of 3 sampled clients (client A) by not ensuring a nursing assessment of an injury of unknown origin to her ear was completed and by not seeking timely medical attention.	W0104	The Area Manager will have the carpet professionally cleaned within the next 30 days. The Area Manager will retrain DSPs on maintenance reporting within 30 days (11/28/12). Maintenance will repair all damaged areas/items within the next 30 days. To ensure future compliance the Property Director, Maintenance crew, Area Manager, and staff will monitor the condition of the carpet and home monthly and notify the appropriate persons of any changes. The Property Director, Maintenance crew, Area Manager, and staff will monitor the home quarterly thereafter. 12/5/12 As soon as the governing body was made aware, an investigation was conducted and appropriate action was taken. All changes in condition with regard to this individual are reported immediately to the Service Coordinator and/or Nurse, documented and family is contacted immediately. In addition, an administrator is notified of the issue. Action is taken in accordance with the policy.	11/28/2012

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	3. A morning observation was conducted at the group home on 10/15/12 from 6:00 A.M. until 7:40 A.M.. Upon entering client A, B, C, D and E's home, the living room carpet had dark black stains throughout the room. The chandelier in the back day room had 3 blown lightbulbs. An interview with Direct Support Professional (DSP) #1 was conducted on 10/15/12 at 6:20 A.M.. When asked how long the carpeting had stains, DSP #1 stated "For a couple of months." When asked how long the light bulbs were blown, she indicated she did not know. An interview with the Service Coordinator (SC) was conducted on 10/17/12 at 2:30 P.M.. When asked how often maintenance repair checks were conducted at the group home, the SC stated, "Monthly." No further documentation was available for review to indicate when the maintenance concerns would be addressed. This federal tag relates to complaint #IN00118284. 9-3-1(a)			

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W0122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, the Condition of Participation: Client Protections was not met as the facility neglected to implement their neglect policy and neglected to protect 1 of 3 sampled clients (client A), from an injury of unknown origin to her ear and hospitalization of client A. Findings include: Please refer to W149. The facility failed to implement their neglect policy and neglected to protect 1 of 3 sampled clients (client A), from an injury of unknown origin to her ear and hospitalization (client A). This federal tag relates to complaint #IN00118284. 9-3-2(a)	W0122	Staff have been re-trained on the requirements for reporting injuries of unknown origin. An investigation will be initiated for all injuries of unknown origin (11/28/12). To ensure future compliance, Service Coordinator and Community Services Nurse will review skin assessment sheets daily to monitor for any new injuries. 12/5/12Investigations for injuries of unknown origin will be conducted according to the policy. In this facility, steps to ensure future failure in the system have been implemented. (See W104). In addition, a system for identification of new injuries vs. injuries previously reported is being developed. This will ensure future compliance. The system failed in that the description of the injury and the actual injury differed.	11/28/2012

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W0149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview, for 1 of 1 investigation records of an injury of unknown origin reviewed involving 1 of 3 sampled clients (client A), the facility neglected to implement its "Policy for Handling Cases of Neglect and Abuse." Findings include: A morning observation was conducted at the group home on 10/15/12 from 6:00 A.M. until 7:40 A.M.. During the entire observation client A was not at the group home. An interview with Direct Support Professional #1 (DSP) was conducted on 10/15/12 at 6:10 A.M.. DSP #1 indicated client A was at the hospital but was not aware why. A review of client A's record was conducted on 10/17/12 at 11:25 A.M.. Review of client A's medical record indicated: Nursing notation dated 10/15/12: "I received a phone call from group home on 10/14/12 at 1:28 P.M., DSP stated she	W0149	Residential Program Dir will review reporting requirements of Abuse, Neglect and exploitation of clients with the Service Coordinator and DSPs and document this review (11/28/12). To monitor for continued compliance, an Area Manager, QMRP or Community Services Nurse will do bi-monthly observations. 12/5/12W149 See W104	11/28/2012

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	noted that consumer woke up this morning with blood on her pillowcase and that her right ear had a scratch on it and that the bleeding had stop (sic). Staff cleanse (sic) the ear and applied triple antibiotic ointment. I ask (sic) staff where the scratch was. I was told it was across the top of her ear not up and down but across the ear. I ask (sic) staff at this time can you pull the ear apart if you used both of your hands again is it a scratch or laceration on top of her ear. Staff told me no that the ear can not be pulled apart. I then ask (sic) if it looked like it could be stitch (sic) and staff told me no that it was a scratch. I informed staff that they have already did (sic) first aid care and to apply an ice pack for 20 minutes to the swollen part of her ear. Call me or [Nurse #2] back if her ear worsens or any other complaints from this problem." No further documentation was noted in client A's medical record to indicate the facility's nursing staff physically assessed client A's noted injury on 10/14/12. A review of investigation record #18218 and #18189 dated 10/15/12 was conducted on 10/19/12 at 2:35 P.M.. Review of the record indicated the following: Incident report dated 10/14/12: "[Client A] woke up with dried blood on her arm			

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	and pillow. Didn't know where blood came from until I (DSP #13) examined her body and discovered there was blood in her hair also and was coming from her ear...Cleaned affected area and put ointment on it and ice. Checked through out the day...Which person (s) was this incident/accident referred to?...Nurse, by phone...Parties notified: [Residential Facility and Management Director name], 10/14/12 at 2:00 P.M., [Behavior Health Director], 10/14/12, 2:00 P.M.. Part B completed by: [Service Coordinator name], 10/15/12 11:30 A.M.." The report did not indicate the facility's administrator was immediately notified of client A's injury of unknown origin. Bureau of Developmental Disabilities Services (BDDS) report dated 10/14/12 indicated: "Received a call at 1:35 P.M. on 10/14/12 from [client A's guardian] (Service Coordinator). She stated that her niece had come to pick [client A] up and noticed she was bleeding. They (client A's niece and DSP #13) traced the blood to her ear where there is approximately a 1 inch curved cut. At this time, it is unclear how the injury occurred...Service Coordinator visited the group home and directed staff to take [client A] to the ER (Emergency Room] for evaluation of the cut. She remains in the hospital at this time and is set for surgery to remove a			

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	blood clot from her ear at noon tomorrow 10/16/12...An investigation into the cause of injury has been initiated and staff has (sic) been suspended at this time." "Date 10/15/12...Phone Interview for investigation: [Client A's niece]: "[Client A's niece] stated that she went to her aunt's (client A) home around 12:15 P.M. on Sunday to take her some snack foods. When she entered the home, [client A] was sitting in a chair in the t.v. room trying to tie her shoe. [Client A's niece] went over to assist [client A] with the shoe and noticed a dark stain on [client A]'s pink shirt. The stain went from the middle of her forearm to the middle of her upper arm (near the muscle). She stated that at first because it was dark brown that maybe it was chocolate, since she has been there to visit [client A] before and she has had food all over her. Taking a closer look she then thought it might be blood. [Client A's niece] asked [DSP #13] if she knew what the stain was and [DSP #13] put on her gloves and stated that it looked like blood. [Client A's niece] lifted her shirt to see where the blood had come from and did not see anything. She told [DSP #13] that they should take her into the bathroom. They both took her shirt off of her and [DSP #13] stated she was going to go look in the bedroom/on the bed. [Client A's			

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	niece] then stated 'I know where it is coming from, from the ear.'...Blood in hair. [DSP #13] came back with the pillow case and stated that there was blood on the case. [DSP #13] then grabbed both the shirt and pillow case and took them some where. [Client A's niece] took [client A] to her room to get her a clean shirt. [Client A's niece] noticed blood on the pillow that had soaked through the pillow case. This is when she took the picture. Both [DSP #13] and [client A's niece] walked [client A] back to the chair in the t.v. room where [DSP #13] put ointment on her ear. [Client A's niece] stated that the stain was enormous and responded blood was still coming out. She asked [DSP #13] if someone was going to see her. [DSP #13] responded that no one would see her because it was Sunday, but she will go to workshop and they will look at her. [DSP #13] and [client A's niece] went to the bedroom to see if she could have hit something/fell out of the bed. Could not see anything that could have caused the injury. [DSP #13] stated she was with her until 10:00 P.M. the night before and had not noticed anything. [Client A's niece] asked her how had she not noticed such a large stain and [DSP #13] stated I did not notice. [Client A's niece] went outside to call her aunt. She told her aunt that she thought [client A] should be seen by a doctor.			

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	Aunt called the house and was told that it was Sunday and [client A] would be seen at the workshop. Aunt called [SC] and then called [client A's niece] back to tell her to go back into the house because staff had told [SC] that she had been aware of the injury. [SC] showed up at the house and told [DSP #13] to take her to the emergency room. [DSP #13] responded oh I'm the one who has to take her. [SC] stated I do not care who takes her, but someone needs to. [DSP #13] got off the van at the hospital and walked away from [client A] because it was raining and she did not want to get wet...it was quite a distance between [client A] and [DSP #13]. [Client A's niece] had to assist [client A] up the curb because [client A] is scared to walk up. While registering [client A] they asked when her birthday was and [client A's niece] did not know. They asked who her doctor was, [client A's niece] did not know and [DSP #13] stated it was a long time since she had to take anyone to the hospital 'I don't know the procedure and I did not bring anything with me.' [Client A's niece] called her aunt for the information. [DSP #13] brought no extra underwear and [client A] wet herself. Had to tape a bedliner around her...I (investigator #1) called [client A's niece] back on 10/16/12 to ask about [DSP #14], the other staff. I asked her where [DSP #14] was when she			

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	arrived at the house. [Client A's niece] stated that neither [DSP #14] or her car was at the house. [Client A's niece] did see [DSP #13] call [DSP #14] on the phone and heard her ask if she had noticed any injury to [client A]. Not long after the call [DSP #14] walked in the door. [Client A's niece] stated that she thought it was strange that [DSP #13] was at the house because the last 3-4 weeks that she has been to see [client A] on the weekend only [DSP #14] has been there. There has (sic) not been 2 staff at the house." "Date 10/15/12...Phone Interview: [Client A's sister]: I spoke with [Client A's sister], [client A]'s aunt. She stated that [client A] was going to have surgery due to a blood clot on her ear. They were going through the back of the ear. They were also going to try to repair the ear and she may have a couple of stitches. Doctor stated to aunt that the injury was caused by a blow/hit to the head/ear." "Date 10/16/12...Main Center: [DSP #13]: I last worked with [client A] on Sunday, October 14, 2012. I noticed the injury when the niece arrived. It was located on the top upper right ear. She gets up on her own. It's normal for [client A] to sit for a while after getting up unless she really is demanded (sic) pop. When			

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	the niece showed up she said she wanted her to go to the hospital. I can't remember my response. When [SC] came she said it was bad enough to go to the hospital and that's when we proceeded to go. When she got there we took her in bathroom to check her body and discovered where the cut was at. I called the nurse first and she said to keep area clean with ointment and ice and they will get her to the doctor on Monday morning. I noticed the blood on the pillow case when the niece discovered it on her sleeve. The reason I put 10 A.M. is because that's the time she came out of the room. At first when I seen (sic) the cut I didn't think it was that bad to go to the hospital but when I seen (sic) it in the light it looked pretty bad. No abuse seen in the (sic) unless other client tries to get to her which is not often or when she hits herself...We proceeded to the hospital. We got in van to go to hospital and sat in ER room for bout (sic) 4 hours. We got her registered. She finally went in the back got the ear cleaned up. The doctor came in and said he wanted to get a closer look at it so he was going to numb her ear and put her in a room. He said that it looked kinda (sic) old but he wasn't sure...I explained it to the nurse as a deep scratch or cut on the ear...When speaking to whomever on the phone, they were demanding her to go to the hospital and I said I had to call the nurse and see what			

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	15G464	A. BUILDING 00 B. WING	10/26/2012

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	she says and we will go from there. She was saying she saw the pictures and wanted her to go now but I had to follow proper procedure...I (investigator #1) asked where [DSP #14] was during this time. She (DSP #13) stated that she was out then stated she was in the basement. I asked her which one was she, out of the house or in the basement. She stated probably out getting lunch, but was only gone 30 minutes...She was out of the house." "Date 10/16/12...Main: [Area Manager]: All group homes are double staffed at all times except during the night shift. Any time staff leaves the group home during their shift a client should be with them." "Date 10/16/12...[Service Coordinator]: I received a call Sunday at 1:35 P.M. from [client A's Sister #2] stating that her niece had visited [client A] and noticed she had dried blood on her sleeve. She stated staff and [client A's niece] took [client A] into the bathroom to do a body check. They didn't find any injury. [Client A's niece] looked in [client A]'s bedroom and noticed blood on her pillow. She then checked [client A]'s head finding blood in her hair and a cut on her right ear. I called the group home speaking to [DSP #13] and instructed her to write an incident report to which she said, 'I guess			

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	I have to do that, huh?' I asked the condition of the cut. [DSP #13] said she'd spoken to [nurse name] who directed her to clean wound and apply antibiotic ointment and that the wound looked much worse due to dried blood but once it was cleaned it looked better. I told her I was on my way...When I arrived [client A] was sitting in her chair. I could see the blood in her hair from entrance. I put on a glove and looked at [client A]'s ear noting a 1 inch cut through her ear. It was still bleeding...I then told both staff, 'Someone needs to take her to the ER.' To this [DSP #13 said 'So I guess it's gotta be me that does that too. If it's like that, its like that, oh o.k..' I said, 'It doesn't matter who takes her, someone needs to grab the emergency folder and take her. Her niece will follow you.' While [DSP #13] got [client A] ready to go, her niece and I went to the bedroom to talk. I noticed little blood spots on the bed. her niece said 'I wanted to take pictures of the pillow and shirt, but the first thing [DSP #13] did was throw them in the washer.' We noticed a hanger (wire) on the bed. I cleaned it to check for blood but there was none. I checked the room for sharp objects or corners but found none. The niece said she felt [DSP #13] had an attitude because when [client A's sister #2] asked that [client A] be taken to get medical attention, that [DSP #13] said 'Oh			

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	we ain't finna (sic) do that, it's the weekend.' When I looked at the incident report it was timed for 10 A.M. as if staff had seen wound before niece arrived, but I had directed one to be done at around 2 P.M.. Staff told me there were no other behavior issues. No one had attacked [client A] and they had no idea what had happened. [Client A's niece] stated her bed was made with the bloody pillow. When I arrived, [client A] was in different clothes and pillow was missing." "Date 10/16/12...Investigator office... [Nurse #1]: I received a phone call from group home on 10/14/12 at 1:28 P.M.. DSP #13 stated that she noted that consumer woke up this morning with blood on her arm and pillowcase and that her right ear was bleeding from what what looks like a scratch. I ask (sic) staff to tell me about this client (sic) she told me that consumer will hit herself a lot of times. She then told me that this consumer's family member was at the house and wanted her to go to the emergency room. Staff told family that she had to call the nurse. DSP told me that they tried to call [nurse #2] (this house nurse) but there was no answer. So I received a call on the emergency. DSP explain (sic) to me that it was a scratch on [client A]'s right ear and that she cleanse (sic) the area (sic) applied triple antibiotic			

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	ointment and the bleeding had stop (sic). I questioned the DSP staff several times about this matter asking was it a scratch or a laceration. DSP staff continued in saying it was a scratch on her ear. I ask (sic) what part of the ear (sic) she told me it was on top of the ear and that the scratch was not vertical but it was horizontal. I then ask (sic) this DSP staff if she could take both of her hands and pull the ear apart where the scratch was noted to be she replied no that it was just a scratch and that the ear was swollen. I informed her a scratch to the ear was not an emergency (sic) to apply an ice pack to the swollen part of the ear for 20 minutes. Staff told me that consumer will not let her hold ice to her ear. I told her to try and if the problem gets worse or any other complaints to please call me back or call her nurse [nurse #2]." "Date 10/16/12: Nurse office...[Nurse #2]: I spoke with family of [client A] at approximately 1:00 P.M. on 10/16/12. She (the sister) stated that during surgery, they cleaned out infection in her ear. She stated that she received 7 stitches. I asked her if the doctor knew how the laceration occurred and she stated blunt force trauma." "Conclusion: Injury of unknown origin-Substantiated. Staff do not know			

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	how injuries occurred. Neglect: Substantiated...Neglect, falsification of documentation, failure to follow agency policy and procedure...Both [staff #13 and #14] terminated for neglect, Falsification of documentation, Failure to follow agency policy and procedure." A review of client A's hospital medical record was conducted on 10/26/12 at 3:20 P.M.. Review of the medical record indicated: Ear Nose Throat (ENT) physician notation dated 10/15/12: "Diagnosis: Laceration to right ear of undetermined duration and origin-hematoma of right ear, possible traumatic origin and bilateral cerum impaction...Ear: Right. There is right ear pain the almost healed laceration which is horizontal in nature. There is a hematoma underneath this. The cartilage of the ear seems to be slightly distorted on the right side. There is impacted sediment in right ear canal...Left: Sediment impaction no obvious trauma." Primary Care Physician (PCP) notation dated 10/15/12: "laceration: Right oracle...Question of neglect...Drain hematoma, repair laceration and remove impacted cerumen bilaterally." A review of the facility's "Policy for			

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	Handling Cases of Neglect and Abuse" dated 12/20/06 was conducted on 10/19/12 at 5:30 P.M.. Review of the facility's policy indicated: "In order to protect the general welfare of the clients, [ARC Northwest Indiana], Inc. has in effect the following policy with regard to abuse, neglect or exploitation of clients by agency staff. II. All allegations of abuse, neglect, humiliation or exploitation will be investigated per agency policy...Neglect- is defined as knowingly placing a client in a situation that poses a threat to his/her health and well-being. Examples include but are not limited to depriving a client of food, clothing, shelter or medical care; not providing adequate personal care, leaving clients unsupervised, etc...Internal investigation refers to a situation that can be successfully addressed within the department (possible examples include...an injury of unknown origin.)...When a staff person is involved, hears about, or witnesses an incident of suspected abuse/neglect or injury to a client...The staff person(s) observing or who has become aware of the incident must immediately: a. secure the safety of the individual(s) involved as appropriate...b. begin the investigation procedure checklist...c. verbally inform his/her immediate supervisor of the suspected incident and/or individual			

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	responsible for that individuals program...d. submit an incident report recording all needed and necessary information to his/her supervisor...e. secure a first aid assessment if there is injury noted or suspected." An interview with Licensed Practical Nurse #1 (LPN) was conducted on 10/26/12 at 2:45 P.M.. When asked if she was contacted on 10/14/12 in regards to client A's injury, LPN #2 stated "Yes, the staff said they attempted to contact the group home assigned nurse, but she did not answer her phone, so the staff called the on-call phone and reached me." When asked if the injury was considered an injury of unknown origin, the LPN stated "Yes." When asked if nursing staff should assess injuries of unknown origin, the LPN stated "I don't know what the policy is on that." When asked if she or any facility nurse went to the group home and physically assessed client A's injury of unknown origin, the LPN stated, "No, I told her I would check it on Monday because she said it was a scratch." When asked if she directed DSP #13 not to take client A to the emergency room after the family member requested she be taken, the LPN stated "Yes, I told her to do first aid care and not to take her to the emergency room because it was a scratch, and scratches do not require emergency			

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	care." An interview with LPN #2 was conducted on 10/26/12 at 4:15 P.M.. When LPN #2, who is the assigned group home nurse, was asked what client A's Physician noted the injury of unknown origin as being caused from, she stated "Blunt force trauma." An interview with the Service Coordinator (SC) was conducted on 10/26/12 at 4:00 P.M.. The SC indicated there should have been two staff at the group home on 10/14/12. The SC indicated nursing staff should have gone to the group home to physically assess client A's injury and further indicated client A should have been taken to the emergency room when the guardian requested client A be transported for medical attention. When asked if she went to the hospital with client A, the SC stated "No." This federal tag relates to complaint #IN00118284. 9-3-2(a)			

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W0153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview, the facility failed for 1 of 1 incident of injury of unknown origin involving 1 of 3 sampled clients (client A), to report the injury of unknown injury immediately to the administrator in accordance with state law. Findings include: A review of investigation record #18218 and #18189 dated 10/15/12 was conducted on 10/19/12 at 2:35 P.M.. Review of the record indicated the following: Incident report dated 10/14/12: "[Client A] woke up with dried blood on her arm and pillow. Didn't know where blood came from until I examined her body and discovered there was blood in her hair also and was coming from her ear...Cleaned affected area and put ointment on it and ice. Checked through out the day...Which person (s) was this incident/accident referred to?...Nurse, by phone...Parties notified: [Residential	W0153	Service Coordinator contacted administrator in regards to this injury. This was not documented on the incident report. Service Coordinator will report all injuries of unknown origin to the administrator within 24 hours (11/28/12). To ensure future compliance, Service Coordinator will document administrator notification on incident report. 12/5/12 W153 See W104 In addition, the administrator contacted will initial the incident/accident report.	11/28/2012

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	Facility and Management Director name], 10/14/12 at 2:00 P.M., [Behavior Health Director], 10/14/12, 2:00 P.M.. Part B completed by: [Service Coordinator name], 10/15/12 11:30 A.M.." The report did not indicate the facility's administrator was immediately notified of client A's injury of unknown origin. An interview was conducted with the Service Coordinator (SC) at the facility's administrative office on 10/19/12 at 4:00 P.M.. The SC indicated the incident was not immediately reported by the group home staff to the administrator. The SC stated "Incidents are to be reported immediately to the administrator." This federal tag relates to complaint #IN00118284. 9-3-2(a)			

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W0192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. Based on observation, record review and interview, the facility failed for 1 of 3 clients observed during medication administration (client C) by staff not demonstrating skills and competency to administer medications as prescribed. Findings include: A morning observation was conducted at the group home on 10/9/12 from 5:50 A.M. until 8:05 A.M.. At 6:40 A.M., client C received her morning prescribed medications. Direct Support Professional (DSP) #1 administered her "OS Cal 500 plus D tablet chewable (supplement)...1 tablet orally twice daily...Take with food/meal...Nabumetone 750 mg (milligram) tablet (Antiarthritic)...1 tablet orally twice daily...Take with food/meal, take with plenty of water...Phenytoin 125 mg/5 ml (milliliter) (anticonvulsant)...Give 6 ml orally twice daily...Take with plenty of water." Client C did not take her medications with food/meal and did not drink any water. Client C ate her breakfast at 7:05 A.M.. An interview with the nurse was	W0192	The Community Service Nurse will re-train DSP's on how to follow medication orders and record results on Medication Administration Record in accordance with physician's order (11/28/12). To ensure future compliance the Community Services Nurse will visit group home at least bi-monthly for three months and at least quarterly thereafter. 12/5/12 W192 Nurse will conduct random checks on medication administration at least two per week for one month, one per week for two months and monthly thereafter.	11/28/2012

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	conducted on 10/26/12 at 11:40 A.M.. The nurse indicated staff should administer all medications as prescribed. The nurse further indicated staff should follow directions on medication labels on medication packets. 9-3-3(a)			

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W0249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review, and interview, the facility failed to implement written objectives during times of opportunity for 2 of 3 sampled clients and 1 additional clients (clients B, C and E). Findings include: A morning observation was conducted at the group home on 10/15/12 from 6:00 A.M. until 7:40 A.M.. During the entire observation period clients B, C and E did not communicate in their home. At 6:25 A.M., Direct Support Professional (DSP) #1 passed client E's prescribed medication. Client E did not point to mouth for oral medication and face for facial wash/cream. At 6:40 A.M., DSP #1 administered client C's prescribed medications. Client C did not point to her medications before they were administered. At 7:18 A.M., DSP #1 administered client B's prescribed medications. Client B did not learn information about her medications. Client B did not use a communication (picture)	W0249	DSPs have been retrained on implementing goals and objectives in accordance with the ISP (11/28/12). To ensure future compliance, the Service Coordinator will observe implementation of the program objectives at least monthly for three months and periodically thereafter. 12/5/12 Service Coordinator will conduct random visits to the home to observe and instruct staff, when necessary, on implementation of objectives toward achievement of those objectives at least two per week for one month, one per week for two months and monthly thereafter.	11/28/2012

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	book and did not learn 5 new words and then signs. Client C did not learn to identify 5 pictures and signs from her communication book. Client E did not learn to use a communication aide. An evening observation was conducted at the group home on 10/15/12 from 5:00 P.M. until 7:00 P.M.. During the entire observation period clients B, C and E did not communicate in their home. Client B did not use a communication (picture) book and did not learn 5 new words and then signs. Client C did not learn to identify 5 pictures and signs from her communication book. Client E did not learn to use a communication aide. A review of client B's record was conducted at the facility's administrative office on 10/17/12 at 11:50 A.M.. Review of client B's Individual Support Plan (ISP) dated 6/8/12 indicated the following: "Will learn to use a communication (picture) book...will learn 5 new words and then sign (stop, go, walk, food, eat)...will continue to learn information about her medications." A review of client C's record was conducted at the facility's administrative office on 10/17/12 at 12:20 P.M.. Review of client C's Individual Support Plan (ISP) dated 6/20/12 indicated the following:			

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	15G464	A. BUILDING 00 B. WING	10/26/2012

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	"Will learn to identify 5 pictures and signs from her communication book...Will continue to learn to point to her medications before they are administered." A review of client E's record was conducted at the facility's administrative office on 10/17/12 at 12:50 P.M.. Review of client E's Individual Support Plan (ISP) dated 6/22/12 indicated the following: "Will learn to use a communication aide...Will learn to point to mouth for oral medication and face for facial wash/cream." The Service Coordinator (SC) was interviewed on 10/17/12 at 2:30 P.M.. The SC stated client objectives should be implemented "during times of opportunity." The SC further indicated staff should have implemented each client's objectives as written. 9-3-4(a)			

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W0318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on record review and interview, the Condition of Participation, Health Care Services, is not met as the facility failed to provide adequate nursing services for 1 of 3 sampled clients (client A). Findings include: Please refer to W331. The facility failed for 1 of 3 sampled clients (client A) by not ensuring a nursing assessment of an injury of unknown origin to her ear was completed and by not seeking timely medical attention. This federal tag relates to complaint #IN00118284. 9-3-6(a)	W0318	Please refer to tag W331	11/28/2012

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W0323	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview, the facility failed for 1 of 3 sampled clients (client A) to provide a hearing evaluation/assessment as recommended by the physician. Findings include: A review of client A's record was conducted on 10/17/12 at 11:25 A.M.. Client A's record indicated a most current hearing evaluation dated 7/22/09 which indicated a return visit in 3 years. Client A's record did not contain evidence she returned for a hearing evaluation in 3 years as recommended. A review of client A's hospital medical record was conducted on 10/19/12 at 3:20 P.M.. Review of the medical record indicated: Doctors notation dated 10/15/12: "Ear: Right. There is right ear pain the almost healed laceration which is horizontal in nature. There is a hematoma underneath this. The cartilage of the ear seems to be slightly distorted on the right side. There is impacted sediment in right ear	W0323	Client A has had a hearing assessment scheduled (11/28/12). To ensure future compliance, Service Coordinator and Nurse will monitor appointments to ensure that clients attend all scheduled appointments.	11/28/2012

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	canal...Left: Sediment impaction no obvious trauma." The Licensed Practical Nurse (LPN) was interviewed on 10/26/12 at 11:40 A.M.. The LPN indicated there was no evidence client A returned as recommended by the physician. 9-3-6(a)			

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W0331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 of 3 sampled clients (client A), the facility failed to provide nursing services for the client's unknown injury. Findings include: A morning observation was conducted at the group home on 10/15/12 from 6:00 A.M. until 7:40 A.M.. During the entire observation client A was not at the group home. An interview with Direct Support Professional #1 (DSP) was conducted on 10/15/12 at 6:10 A.M.. DSP #1 indicated client A was at the hospital but was not aware why. A review of client A's record was conducted on 10/17/12 at 11:25 A.M.. Review of client A's medical record indicated: Nursing notation dated 10/15/12: "I received a phone call from group home on 10/14/12 at 1:28 P.M., DSP stated she noted that consumer woke up this morning with blood on her pillowcase and that her right ear had a scratch on it and	W0331	Community Services Nurse will assess all injuries of unknown origin if there is any question the injury needs medical attention. If A Nurse is not able to assess the injury in person, staff will be directed to Urgent Care or the local Emergency Room. Staff have been re-trained on properly describing injuries to nursing staff (11/28/12). To ensure future compliance, Nurses will continue to work with staff on determining severity of injuries. 12/5/12Nurse is to evaluate the issue/injury based upon the information given to them. In this case, the information/description was not an accurate descriptor. (See W104, 122, and 192 for ensurance to compliance) Nursing care is available 24 hours per day, including weekends and holidays. A Nurse is on-call and available to the facility via telephone and if necessary, physically in the home to evaluate/assess an issue.	11/28/2012

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	that the bleeding had stop (sic). Staff cleanse (sic) the ear and applied triple antibiotic ointment. I ask (sic) staff where the scratch was. I was told it was across the top of her ear not up and down but across the ear. I ask (sic) staff at this time can you pull the ear apart if you used both of your hands again is it a scratch or laceration on top of her ear. Staff told me no that the ear can not be pulled apart. I then ask (sic) if it looked like it could be stitch (sic) and staff told me no that it was a scratch. I informed staff that they have already did (sic) first aid care and to apply an ice pack for 20 minutes to the swollen part of her ear. Call me or [Nurse #2] back if her ear worsens or any other complaints from this problem." No further documentation was noted in client A's medical record to indicate the facility's nursing staff physically assessed client A's noted injury on 10/14/12. A review of investigation record #18218 and #18189 dated 10/15/12 was conducted on 10/19/12 at 2:35 P.M.. Review of the record indicated the following: Incident report dated 10/14/12: "[Client A] woke up with dried blood on her arm and pillow. Didn't know where blood came from until I (DSP #13) examined her body and discovered there was blood			

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	in her hair also and was coming from her ear...Cleaned affected area and put ointment on it and ice. Checked through out the day...Which person (s) was this incident/accident referred to?...Nurse, by phone...Parties notified: [Residential Facility and Management Director name], 10/14/12 at 2:00 P.M., [Behavior Health Director], 10/14/12, 2:00 P.M.. Part B completed by: [Service Coordinator name], 10/15/12 11:30 A.M.." The report did not indicate the facility's administrator was immediately notified of client A's injury of unknown origin. Bureau of Developmental Disabilities Services (BDDS) report dated 10/14/12 indicated: "Received a call at 1:35 P.M. on 10/14/12 from [client A's guardian] (Service Coordinator). She stated that her niece had come to pick [client A] up and noticed she was bleeding. They (client A's niece and DSP #13) traced the blood to her ear where there is approximately a 1 inch curved cut. At this time, it is unclear how the injury occurred...Service Coordinator visited the group home and directed staff to take [client A] to the ER (Emergency Room] for evaluation of the cut. She remains in the hospital at this time and is set for surgery to remove a blood clot from her ear at noon tomorrow 10/16/12...An investigation into the cause of injury has been initiated and staff has			

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	(sic) been suspended at this time." "Date 10/15/12...Phone Interview for investigation: [Client A's niece]: "[Client A's niece] stated that she went to her aunt's (client A) home around 12:15 P.M. on Sunday to take her some snack foods. When she entered the home, [client A] was sitting in a chair in the t.v. room trying to tie her shoe. [Client A's niece] went over to assist [client A] with the shoe and noticed a dark stain on [client A]'s pink shirt. The stain went from the middle of her forearm to the middle of her upper arm (near the muscle). She stated that at first because it was dark brown that maybe it was chocolate, since she has been there to visit [client A] before and she has had food all over her. Taking a closer look she then thought it might be blood. [Client A's niece] asked [DSP #13] if she knew what the stain was and [DSP #13] put on her gloves and stated that it looked like blood. [Client A's niece] lifted her shirt to see where the blood had come from and did not see anything. She told [DSP #13] that they should take her into the bathroom. They both took her shirt off of her and [DSP #13] stated she was going to go look in the bedroom/on the bed. [Client A's niece] then stated 'I know where it is coming from, from the ear.'...Blood in hair. [DSP #13] came back with the			

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	pillow case and stated that there was blood on the case. [DSP #13] then grabbed both the shirt and pillow case and took them some where. [Client A's niece] took [client A] to her room to get her a clean shirt. [Client A's niece] noticed blood on the pillow that had soaked through the pillow case. This is when she took the picture. Both [DSP #13] and [client A's niece] walked [client A] back to the chair in the t.v. room where [DSP #13] put ointment on her ear. [Client A's niece] stated that the stain was enormous and responded blood was still coming out. She asked [DSP #13] if someone was going to see her. [DSP #13] responded that no one would see her because it was Sunday, but she will go to workshop and they will look at her. [DSP #13] and [client A's niece] went to the bedroom to see if she could have hit something/fell out of the bed. Could not see anything that could have caused the injury. [DSP #13] stated she was with her until 10:00 P.M. the night before and had not noticed anything. [Client A's niece] asked her how had she not noticed such a large stain and [DSP #13] stated I did not notice. [Client A's niece] went outside to call her aunt. She told her aunt that she thought [client A] should be seen by a doctor. Aunt called the house and was told that it was Sunday and [client A] would be seen at the workshop. Aunt called [SC] and			

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	then called [client A's niece] back to tell her to go back into the house because staff had told [SC] that she had been aware of the injury. [SC] showed up at the house and told [DSP #13] to take her to the emergency room. [DSP #13] responded oh I'm the one who has to take her. [SC] stated I do not care who takes her, but someone needs to. [DSP #13] got off the van at the hospital and walked away from [client A] because it was raining and she did not want to get wet...it was quite a distance between [client A] and [DSP #13]. [Client A's niece] had to assist [client A] up the curb because [client A] is scared to walk up. While registering [client A] they asked when her birthday was and [client A's niece] did not know. They asked who her doctor was, [client A's niece] did not know and [DSP #13] stated it was a long time since she had to take anyone to the hospital 'I don't know the procedure and I did not bring anything with me.' [Client A's niece] called her aunt for the information. [DSP #13] brought no extra underwear and [client A] wet herself. Had to tape a bedliner around her...I (investigator #1) called [client A's niece] back on 10/16/12 to ask about [DSP #14], the other staff. I asked her where [DSP #14] was when she arrived at the house. [Client A's niece] stated that neither [DSP #14] or her car was at the house. [Client A's niece] did			

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	see [DSP #13] call [DSP #14] on the phone and heard her ask if she had noticed any injury to [client A]. Not long after the call [DSP #14] walked in the door. [Client A's niece] stated that she thought it was strange that [DSP #13] was at the house because the last 3-4 weeks that she has been to see [client A] on the weekend only [DSP #14] has been there. There has (sic) not been 2 staff at the house." "Date 10/15/12...Phone Interview: [Client A's sister]: I spoke with [Client A's sister], [client A]'s aunt. She stated that [client A] was going to have surgery due to a blood clot on her ear. They were going through the back of the ear. They were also going to try to repair the ear and she may have a couple of stitches. Doctor stated to aunt that the injury was caused by a blow/hit to the head/ear." "Date 10/16/12...Main Center: [DSP #13]: I last worked with [client A] on Sunday, October 14, 2012. I noticed the injury when the niece arrived. It was located on the top upper right ear. She gets up on her own. It's normal for [client A] to sit for a while after getting up unless she really is demanded (sic) pop. When the niece showed up she said she wanted her to go to the hospital. I can't remember my response. When [SC] came she said it			

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	was bad enough to go to the hospital and that's when we proceeded to go. When she got there we took her in bathroom to check her body and discovered where the cut was at. I called the nurse first and she said to keep area clean with ointment and ice and they will get her to the doctor on Monday morning. I noticed the blood on the pillow case when the niece discovered it on her sleeve. The reason I put 10 A.M. is because that's the time she came out of the room. At first when I seen (sic) the cut I didn't think it was that bad to go to the hospital but when I seen (sic) it in the light it looked pretty bad. No abuse seen in the (sic) unless other client tries to get to her which is not often or when she hits herself...We proceeded to the hospital. We got in van to go to hospital and sat in ER room for bout (sic) 4 hours. We got her registered. She finally went in the back got the ear cleaned up. The doctor came in and said he wanted to get a closer look at it so he was going to numb her ear and put her in a room. He said that it looked kinda (sic) old but he wasn't sure...I explained it to the nurse as a deep scratch or cut on the ear...When speaking to whomever on the phone, they were demanding her to go to the hospital and I said I had to call the nurse and see what she says and we will go from there. She was saying she saw the pictures and wanted her to go now but I had to follow			

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	proper procedure...I (investigator #1) asked where [DSP #14] was during this time. She (DSP #13) stated that she was out then stated she was in the basement. I asked her which one was she, out of the house or in the basement. She stated probably out getting lunch, but was only gone 30 minutes...She was out of the house." "Date 10/16/12...Main: [Area Manager]: All group homes are double staffed at all times except during the night shift. Any time staff leaves the group home during their shift a client should be with them." "Date 10/16/12...[Service Coordinator]: I received a call Sunday at 1:35 P.M. from [client A's Sister #2] stating that her niece had visited [client A] and noticed she had dried blood on her sleeve. She stated staff and [client A's niece] took [client A] into the bathroom to do a body check. They didn't find any injury. [Client A's niece] looked in [client A]'s bedroom and noticed blood on her pillow. She then checked [client A]'s head finding blood in her hair and a cut on her right ear. I called the group home speaking to [DSP #13] and instructed her to write an incident report to which she said, 'I guess I have to do that, huh?' I asked the condition of the cut. [DSP #13] said she'd spoken to [nurse name] who directed her			

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	to clean wound and apply antibiotic ointment and that the wound looked much worse due to dried blood but once it was cleaned it looked better. I told her I was on my way...When I arrived [client A] was sitting in her chair. I could see the blood in her hair from entrance. I put on a glove and looked at [client A]'s ear noting a 1 inch cut through her ear. It was still bleeding...I then told both staff, 'Someone needs to take her to the ER.' To this [DSP #13 said 'So I guess it's gotta be me that does that too. If it's like that, its like that, oh o.k..' I said, 'It doesn't matter who takes her, someone needs to grab the emergency folder and take her. Her niece will follow you.' While [DSP #13] got [client A] ready to go, her niece and I went to the bedroom to talk. I noticed little blood spots on the bed. her niece said 'I wanted to take pictures of the pillow and shirt, but the first thing [DSP #13] did was throw them in the washer.' We noticed a hanger (wire) on the bed. I cleaned it to check for blood but there was none. I checked the room for sharp objects or corners but found none. The niece said she felt [DSP #13] had an attitude because when [client A's sister #2] asked that [client A] be taken to get medical attention, that [DSP #13] said 'Oh we ain't finna (sic) do that, it's the weekend.' When I looked at the incident report it was timed for 10 A.M. as if staff			

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	15G464	A. BUILDING 00 B. WING	10/26/2012

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ARC OF NORTHWEST INDIANA INC, THE	2414 WOODLANE MERRILLVILLE, IN 46410

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	had seen wound before niece arrived, but I had directed one to be done at around 2 P.M.. Staff told me there were no other behavior issues. No one had attacked [client A] and they had no idea what had happened. [Client A's niece] stated her bed was made with the bloody pillow. When I arrived, [client A] was in different clothes and pillow was missing." "Date 10/16/12...Investigator office... [Nurse #1]: I received a phone call from group home on 10/14/12 at 1:28 P.M.. DSP #13 stated that she noted that consumer woke up this morning with blood on her arm and pillowcase and that her right ear was bleeding from what what looks like a scratch. I ask (sic) staff to tell me about this client (sic) she told me that consumer will hit herself a lot of times. She then told me that this consumer's family member was at the house and wanted her to go to the emergency room. Staff told family that she had to call the nurse. DSP told me that they tried to call [nurse #2] (this house nurse) but there was no answer. So I received a call on the emergency. DSP explain (sic) to me that it was a scratch on [client A]'s right ear and that she cleanse (sic) the area (sic) applied triple antibiotic ointment and the bleeding had stop (sic). I questioned the DSP staff several times about this matter asking was it a scratch			

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	or a laceration. DSP staff continued in saying it was a scratch on her ear. I ask (sic) what part of the ear (sic) she told me it was on top of the ear and that the scratch was not vertical but it was horizontal. I then ask (sic) this DSP staff if she could take both of her hands and pull the ear apart where the scratch was noted to be she replied no that it was just a scratch and that the ear was swollen. I informed her a scratch to the ear was not an emergency (sic) to apply an ice pack to the swollen part of the ear for 20 minutes. Staff told me that consumer will not let her hold ice to her ear. I told her to try and if the problem gets worse or any other complaints to please call me back or call her nurse [nurse #2]." "Date 10/16/12: Nurse office...[Nurse #2]: I spoke with family of [client A] at approximately 1:00 P.M. on 10/16/12. She (the sister) stated that during surgery, they cleaned out infection in her ear. She stated that she received 7 stitches. I asked her if the doctor knew how the laceration occurred and she stated blunt force trauma." "Conclusion: Injury of unknown origin-Substantiated. Staff do not know how injuries occurred. Neglect: Substantiated...Neglect, falsification of documentation, failure to follow agency			

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	policy and procedure...Both [staff #13 and #14] terminated for neglect, Falsification of documentation, Failure to follow agency policy and procedure." A review of client A's hospital medical record was conducted on 10/26/12 at 3:20 P.M.. Review of the medical record indicated: Ear Nose Throat (ENT) physician notation dated 10/15/12: "Diagnosis: Laceration to right ear of undetermined duration and origin-hematoma of right ear, possible traumatic origin and bilateral cerum impaction...Ear: Right. There is right ear pain the almost healed laceration which is horizontal in nature. There is a hematoma underneath this. The cartilage of the ear seems to be slightly distorted on the right side. There is impacted sediment in right ear canal...Left: Sediment impaction no obvious trauma." Primary Care Physician (PCP) notation dated 10/15/12: "laceration: Right oracle...Question of neglect...Drain hematoma, repair laceration and remove impacted cerumen bilaterally." An interview with Licensed Practical Nurse #1 (LPN) was conducted on 10/26/12 at 2:45 P.M.. When asked if she was contacted on 10/14/12 in regards to			

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	client A's injury, LPN #2 stated "Yes, the staff said they attempted to contact the group home assigned nurse, but she did not answer her phone, so the staff called the on-call phone and reached me." When asked if the injury was considered an injury of unknown origin, the LPN stated "Yes." When asked if nursing staff should assess injuries of unknown origin, the LPN stated "I don't know what the policy is on that." When asked if she or any facility nurse went to the group home and physically assessed client A's injury of unknown origin, the LPN stated, "No, I told her I would check it on Monday because she said it was a scratch." When asked if she directed DSP #13 not to take client A to the emergency room after the family member requested she be taken, the LPN stated "Yes, I told her to do first aid care and not to take her to the emergency room because it was a scratch, and scratches do not require emergency care." An interview with LPN #2 was conducted on 10/26/12 at 4:15 P.M.. When LPN #2, who is the assigned group home nurse, was asked what client A's Physician noted the injury of unknown origin as being caused from, she stated "Blunt force trauma." An interview with the Service			

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	Coordinator (SC) was conducted on 10/26/12 at 4:00 P.M.. The SC indicated there should have been two staff at the group home on 10/14/12. The SC indicated nursing staff should have gone to the group home to physically assess client A's injury and further indicated client A should have been taken to the emergency room when the guardian requested client A be transported for medical attention. When asked if she went to the hospital with client A, the SC stated "No." No documentation was available for review to indicate nursing staff assessed/treated client A's injury of unknown injury. This federal tag relates to complaint #IN00118284. 9-3-6(a)			